

Public Employees Benefits Board (PEBB) Program
Underwritten by Standard Insurance Company

Long Term Disability (LTD)
Enrollment/Change Form

Employees	Personnel, payroll, or benefits office staff
<ul style="list-style-type: none">Type or print clearly in ink.If you do not wish to enroll in optional LTD coverage, complete Sections 1 & 2.If you wish to enroll in or change optional LTD coverage, complete Sections 1 & 3. Your personnel, payroll, or benefits office will automatically enroll you in Part A (Basic) LTD coverage.Return this form to your personnel, payroll, or benefits office.If you're requesting optional coverage that requires prior approval, you must also complete the LTD Evidence of Insurability Form and send it to Standard Insurance Company.	<ul style="list-style-type: none">Review Sections 1 – 3 for completeness and accuracy, and complete Section 4.Do not send the form to Standard Insurance Company or the PEBB Program.

SECTION 1: PERSONAL INFORMATION

Employee completes this section.

Social Security Number	Employee I.D. Number	Last Name	First Name	Middle Initial
Street Address	Apartment Number	City	State	ZIP Code + 4
Mailing Address (if different from above)	Apartment Number	City	State	ZIP Code + 4
Agency Name	Agency Code	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number – Daytime Phone Number – Evening

SECTION 2: BASIC LTD COVERAGE ONLY

Employee completes this section.

Your employer pays for Plan A (Basic) LTD coverage. Your personnel, payroll, or benefits office will enroll you in this coverage at no cost to you.

If you wish to enroll in Plan A (Basic) LTD coverage only and do not wish to enroll in optional LTD coverage, sign and date below.

I hereby reject my opportunity to enroll in optional long term disability coverage. By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of insurance benefits.

This form replaces all previous forms and submissions I have made for PEBB long term disability coverage.

Employee's signature _____ Date _____

SECTION 3: BASIC AND OPTIONAL LTD COVERAGE

Employee completes this section.

I wish to:

- ☐ Enroll in optional LTD coverage; choose a waiting period.
- ☐ Increase the waiting period for my LTD coverage; choose a waiting period.
- ☐ Decrease the waiting period for optional LTD coverage; choose a waiting period.
- ☐ Cancel my optional LTD coverage.

If you wish to enroll in optional LTD coverage after 31 days of becoming newly eligible for PEBB coverage, or decrease the waiting period for your optional LTD coverage, you must also complete the LTD Evidence of Insurability Form.

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of insurance benefits.

I allow my employer to deduct money from my earnings to pay for any optional insurance I requested and approved by Standard Insurance Company. This form replaces all previous forms and submissions I have made for PEBB long term disability insurance.

Employee's signature _____ Date _____

Choose a waiting period:

- ☐ 30 days
- ☐ 60 days
- ☐ 90 days
- ☐ 120 days
- ☐ 180 days
- ☐ 240 days
- ☐ 300 days
- ☐ 360 days

SECTION 4: AGENCY/CARRIER INFORMATION

Personnel, payroll, or benefits office completes this section.

Current Agency Hire Date	Initial Eligibility Date for PEBB Benefits	Effective Date of Optional Coverage (if no approval required)	Standard Insurance Company has: <input type="checkbox"/> Approved Effective date _____
Employee's Monthly Earnings \$	Employee's Current Coverage <input type="checkbox"/> Basic LTD only <input type="checkbox"/> Optional LTD—waiting period _____ days		<input type="checkbox"/> Declined <input type="checkbox"/> Pended—information incomplete

2013 PEBB LONG TERM DISABILITY INSURANCE CONTRACTOR

Standard Insurance Company, Attn: Medical Underwriting Department, 900 SW 5th, Portland, OR 97204-1282
Phone: 1-800-368-2860

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.